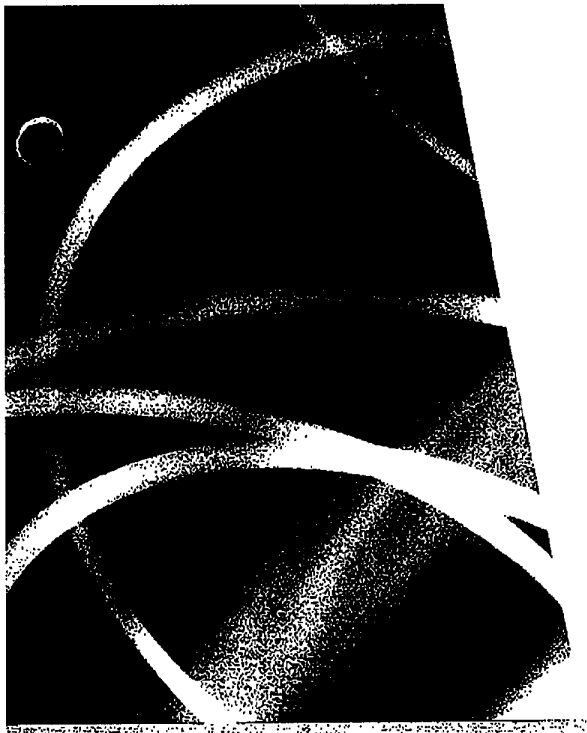

DELPHI
Automotive Systems

health care 2000

Health Care Decision Guide

For Delphi Salaried Retirees and Surviving Spouses

To enroll for Health Care 2000:
Call 1-800-462-5184
October 4–15, 1999

What's Inside

IMPORTANT NOTICE
For Retirees of Delphi Automotive Systems Retiring On or After February 1, 1999

Delphi Automotive Systems became a wholly independent, free-standing company effective May 28, 1999. It is now completely separate from General Motors. As a result, Delphi retirees are now participants in retiree benefit plans and programs sponsored by Delphi, which are comparable to those of General Motors.

For the 2000 enrollment, the options described in this *Health Care Decision Guide* apply to the Benefit Plans and Programs sponsored by Delphi.

Enrollment Info

Your enrollment material is divided into two booklets.

Your *Health Care Decision Guide* contains:

- Updates for 2000
- Health plan option performance information
- Health care plan features
- Enrollment options
- How to verify dependent information

***Your Personal Enrollment Information* contains:**

- A list of your dependents and your current coverage
- The health care options available to you
- Medical option performance information
- Decision Worksheet
- Instructions about how to change your health care option
- Resources for further information

The benefits provided under the Delphi Benefit Plans and Programs are the same as those offered under the GM Benefit Plans and Programs. Therefore, the benefit descriptions in the GM booklet titled *Your Benefits in Retirement* (July 1996) apply to your Delphi benefits and can be used as a reference. (The new features described on pages 5–6 of this booklet are not included.) If you have not received a copy of *Your Benefits in Retirement*, call the Retiree Servicing Center at 1-800-828-9236.

This 2000 *Health Care Decision Guide* for Delphi Salaried Retirees and Surviving Spouses briefly describes certain Salaried Health Care Program features. It does not cover all the details about the Program. Those are found in plan documents that have the final word over any other oral or written statement. Delphi reserves the right to increase, decrease, amend, modify, suspend or terminate their benefit plans at any time (see page 27). This booklet — and the benefits described within — do not imply any guarantees.

Five Steps to Your Enrollment

1 Find out what's new for 2000

Make sure you understand how the new features work with the Basic Medical Plan (BMP), Enhanced Medical Plan (EMP) and Preferred Provider Organizations (PPOs) (where available). Also be aware of copayment changes for some HMOs and new resources for accessing health care information. For help with this step, see:

- "Updates for 2000" on page 4 of this guide
- Additional resources listed on the back of *Your Personal Enrollment Information*

2 Review your health care options

Think about the health care services you and your dependents use, and what your total out-of-pocket cost might be for services under each of the options available. For help with this step, see:

- Plan features of the medical, dental, vision and ECC options in this guide
- "Plan Comparison" charts for medical and dental in *Your Personal Enrollment Information*
- Information Request Line resource on page 4 of this guide

3 Factor in quality

Delphi continues to work closely with health plans to improve the quality and delivery of health care services. Measuring quality is part of this process, and these measures are an important consideration when making your health care decision. For help with this step, see:

- "Health Plan Performance Information" on pages 9–11 of this guide
- "Quality Report Card" on page 4 of *Your Personal Enrollment Information*

4 Verify any eligible dependents

Review the accuracy of your dependent information/data, including eligibility, relationship, date of birth and Social Security number. For help with this step, see:

- Dependent data listed on page 2 of *Your Personal Enrollment Information*
- Dependent eligibility requirements on pages 22–26 of this guide

5 Decide which option you want

Complete the "Decision Worksheet" in *Your Personal Enrollment Information*. If you want to change your coverage elections and/or verify your dependents, call 1-800-462-5184.

If you want your 1999 health care coverage elections to continue with year 2000 contributions — and your eligible dependent information is accurate — **do nothing.**

If you want to change your elections or if your 1999 health care option is not available in 2000, you must call the Enrollment Center and elect a different plan.

If you do not call...

Your 1999 Delphi health care option coverages will continue (if the option is available) — as shown on page 11 of *Your Personal Enrollment Information* — with year 2000 contribution rates, and you will have represented that the dependents listed in your enrollment information continue to qualify as eligible dependents.

Enrollment period: October 4 - 15, 1999

Enrollment Center: 1-800-462-5184

UPDATES

Updates for 2000

New Chart Compares Medical Plan Information

We continually look for ways to improve quality in the information you use to make your enrollment decisions. This means providing the right amount of detail in an easy-to-use format. For 2000, we are introducing a new medical plan comparison chart — on pages 6 and 7 of *Your Personal Enrollment Information* — as part of this effort.

The new comparison chart is designed to help you quickly review your medical options without having to read through pages of details on each plan. It provides a side-by-side overview of each of the medical plans available to you through enrollment — all on one chart.

As you review the new comparison chart, it's important to note that the plan details and benefits for each option remain unchanged from last year. However, copayments for some HMOs have increased slightly. This means that most Delphi-offered HMOs now have the same copayments:

- Outpatient services — $5 copayment
- Prescription drugs — $5 copayment
- Emergency care — $25 copayment

(Note: Copayment information is also shown on the medical plan comparison chart.)

Finding the Details on Your Medical Plan Options

The new medical plan comparison chart replaces the detailed medical plan benefit summaries that were provided in previous years. If you would like the detailed information, it is still available from these sources:

- **Information Request Line** — to have the health plan summaries either sent by fax to you or sent to you through the mail
  - Call toll-free **1-800-462-5185**, September 27 through October 15 (24 hours a day, 7 days a week)
  - **If you have a fax machine**, enter the four-digit codes (listed on the comparison chart next to each health plan in *Your Personal Enrollment Information* booklet) of the options for which you would like more information along with your fax number; the information will then be sent by fax to you
  - **If you do not have a fax machine**, follow the system prompts to have **all** health plan summaries for which you are eligible mailed to you

If you do not have access to a fax machine, make sure you call early enough to allow time for mailing so you will receive the information before the enrollment deadline.

- ***Health Pages*** — to access the health plan summaries **and** detailed quality information on the Internet
  - Visit the *Health Pages* site at www.gm.thehealthpages.com

New ID Cards and Network Discounts for United HealthCare

If you are a non-Medicare enrollee in Basic Medical Plan (BMP) or Enhanced Medical Plan (EMP) with United HealthCare as your carrier for 2000, you will receive a new ID card. In addition to the normal arrangements regarding provider selection and reimbursement, you will have the opportunity to access discounts from doctors and hospitals that participate with the "Options PPO" starting in January 2000. To receive information about participating providers, call 1-800-241-9964 or check the Internet on (www. provider.uhc.com/delphi).

New Features in Place for 2000

In April 1999, we introduced three Health Care Program new features for all salaried **non-Medicare** retirees, surviving spouses and eligible dependents enrolled in the Basic Medical Plan (BMP), Enhanced Medical Plan (EMP) and Preferred Provider Organizations (PPOs):

- Care Management
- Disease Management
- Centers of Excellence

You may recall reading about the new features in last year's enrollment materials or in a brochure that was sent earlier this year to retirees enrolled in the BMP, EMP and PPOs. **Now that the new features are in place, it's important to remember our aim — to improve the quality of health care.**

A key aspect of the Care Management feature is a "best practices" review, which helps ensure the medical necessity and appropriateness of your treatment. This means that surgical procedures, hospital stays, skilled nursing facility admissions and home health care services need to be reviewed **before** treatment is received.

Call Health International (HI) toll-free at 1-877-299-4635 **in advance of procedures that require a review.** Nurses and board-certified physicians at HI can educate and present alternatives to help you make informed decisions about the treatment that you believe is best for you.

As previously communicated, if you do not call Health International when necessary, you may be required to pay an additional $200 per occurrence (up to $600 per year) starting in the year 2000. These amounts are in addition to any normal deductible and copayments, and will not be applied to your out-of-pocket maximum.

A chart showing the "New Features At-A-Glance" appears on page 6.

New Features: At-A-Glance

Care Management

- Provides a "best practices" review for certain types of medical treatment
- Assists patients in working with today's complex health care system and provides more information for decision-making when care is needed

Disease Management

- A confidential and voluntary feature that focuses on improving quality of life for those who live with a chronic medical condition
- Provides a personalized, coordinated plan of care — with your physicians — that can help control a chronic condition and improve health

Centers of Excellence

- A confidential and voluntary feature that provides information about and access to Centers of Excellence (COE) — providers and hospitals nationally recognized for treating specific serious medical conditions
- Provides financial assistance, in some cases, for the patient and a family member to travel to a COE for treatment

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Care Management — What you need to do:

- Call Health International (HI) toll-free at **1-877-299-4635** before surgeries, hospital stays, skilled nursing facility admissions or home health care services.
  - An emergency room visit does not require a call unless it leads to a hospital admission. If admitted, call HI within 48 hours.
  - If you are not sure whether a procedure requires a review, call HI toll-free at **1-877-299-4635.** HI is open 24 hours a day, 7 days a week.

Disease Management and Centers of Excellence — How they work:

- These two features are voluntary, and referrals are typically made through the Care Management feature. Call Health International toll-free at **1-877-299-4635** if you would like to find out more.

Quality Drivers in Health Care

There are four factors that drive quality in health care.

1. **Public policy about health care** — government regulations, on the state and Federal level.
2. **The design of our health care programs** — what is covered, who is covered, the level of cost sharing, plans available, etc.
3. **The health care delivery system** — the doctors, pharmacists, labs, hospitals and other professionals and services that care for people when they need it, as well as insurance companies and other benefit administrators.
4. **Individual health and behavior** — how healthy we are, how hard we work to maintain our health, and the choices we make when we are ill or injured and need treatment.

All of these factors are interrelated, and Delphi continually works in all these areas to help improve the quality of health care for our retirees and their families.

The Quest for Quality

We are committed to improving the quality of health care and the quality of life of all Delphi retirees and their families. We are constantly striving to assess and encourage improvement in health care quality while developing tools to help you — the consumer — make informed health care decisions. Over the past several years, a number of initiatives have been developed in our quest for quality.

For Everyone...

- **Leadership.** Through our involvement in the national movement for improving the quality of health care, we support groups such as the National Committee for Quality Assurance (NCQA), the Foundation for Accountability, the National Forum for Health Care Quality Measurement and Reporting, and the Competitive Pricing Advisory Committee for the governmental agency responsible for Medicare. These independent national groups are dedicated to improving health care delivery for everyone.
- **Research.** A significant portion of our philanthropic contributions is focused on breast cancer and prostate cancer research to help improve the quality of life for people everywhere.

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For You...

- **LifeSteps.** The largest corporate-sponsored wellness and health promotion program in the world, LifeSteps helps people assess how healthy and fit they are. It provides a variety of educational tools that increase awareness about personal health issues and safety. The confidential LifeSteps Health Risk Appraisal (HRA) helps evaluate a person's health status and develop plans to maintain and improve it.
- **Continuous Improvement.** Using nationally recognized standards as a guide, we communicate our expectations about performance to the individual health plans and identify where each plan falls short and what can be done to improve. By working with each plan, our approach helps promote continuous improvement in the quality of the health plans offered to Delphi retirees and their families.
- **Quality Report Card.** Automakers continue to work together to create better ways to measure and report health plan quality. This year's report card tells you about HMO quality in five categories that may be important to you and your family — **Accreditation, Doctor Communication and Service, Access and Service, Staying Healthy and Getting Better/Living with Illness.** Look for the report card on page 4 of *Your Personal Enrollment Information* booklet. Use it to compare HMOs on quality — and see how well they are meeting their members' health care needs.
- **Health Pages.** Delphi retirees can use the Internet to gather information useful to help make informed health care decisions and to stay healthy. The site is located at (www.gm.thehealthpages.com). See page 14 of this guide for details about this popular web site.
- **New Features.** To help you and your family receive treatment based on the best medical evidence available, we introduced three new features to the Salaried Health Care Program in April 1999 — Care Management, Disease Management and Centers of Excellence. See pages 5–6 of this guide to learn how these features can help non-Medicare retirees, surviving spouses and eligible dependents make better, more informed health care decisions.

If you have any questions or comments about our health care programs or quality initiatives, call the Retiree Servicing Center at 1-800-828-9236.

Health Plan Performance Information for 2000

Adding Quality to Your Health Plan Decision

Choosing a health plan is an important decision. You have to think about the **benefits** you and your family need, the **costs** you can afford and how easy it will be to get care when you need it. You also need to think about the **quality** of the care you will receive.

It's important to compare quality because some health plans, doctors and hospitals do a better job than others. Delphi is offering you access to some of the best health organizations in the nation — but even among these strong organizations, **real quality differences exist**.

Automakers are working together to create new and better ways to measure the quality of health plans — and we are reporting the results to you. This measurement and reporting project is part of our efforts to bring you the best health care possible.

> Quality health care means that health organizations, doctors and other professionals are striving to do the right things at the right time in the right amount for the right people. It also means that the things they do help ensure the best possible results. With quality care, people feel better, function better and enjoy a better quality of life.

Starting with HMOs

The first phase of the joint project focuses on measures for HMOs — Health Maintenance Organizations. Over time, they plan to bring you quality information for plans of all types — including the Basic Medical Plan, Enhanced Medical Plan and Preferred Provider Organizations (PPOs).

On page 4 of *Your Personal Enrollment Information* booklet, you will find a quality report card that lets you compare HMOs in five areas that may be important to you and your family:

- **Accreditation** — have the HMO's quality-related structures, processes and performance been approved by an independent national organization?
- **Doctor Communication and Service** — how well do doctors in the HMO talk to, listen to and care for their patients?
- **Access and Service** — how easy is it for HMO members to get the services and treatments they need?
- **Staying Healthy** — how well does the HMO help members stay healthy and avoid illness through preventive care, reduction of health risks, early detection of illness and education?
- **Getting Better/Living with Illness** — how well does the HMO care for people when they are sick, injured or living with a chronic illness, such as diabetes?

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How the Report Card Works

The report card compares all of the plans General Motors, DaimlerChrysler and Ford offer their retirees and employees. It does not compare these plans to all of the plans in the nation.

An HMO can earn from one to five stars in each of the five categories based on its performance in 1998:

★★★★★ The HMO is in the highest 10 percent of all HMOs evaluated

★★★★ The HMO is significantly above average

★★★ The HMO is average

★★ The HMO is significantly below average

★ The HMO is in the lowest 10 percent of all HMOs evaluated

As you look at the report card, you will notice that some HMOs do better in some categories than in others. Look for HMOs with the most stars in the categories that are most important to you and your family.

Here is what the stars mean in each category:

Accreditation
YES means that the HMO:

- Has been accredited by the National Committee for Quality Assurance (NCQA is an independent national organization that reviews, evaluates and accredits HMOs)

NO means that the HMO:

- Was eligible for NCQA accreditation but did not apply or failed to receive accreditation

Doctor Communication and Service
More stars mean that — based on the information reviewed — more members:

- Have doctors who communicate well
- Have doctors who spend enough time with them and know their medical history
- Give their personal doctor, specialists and overall care high ratings

Access and Service
More stars mean that — based on the information reviewed — more members:

- Have an easy time getting the care they need
- Get care without long waits
- Have an easy time getting a referral to a specialist
- Have their complaints handled well by the health plan
- Give their health plan high ratings

Staying Healthy
More stars mean that — based on the information reviewed — more members:

- Get appropriate screenings for breast cancer
- Get flu shots as older adults
- Get advice to exercise and eat healthy

Getting Better/Living with Illness
More stars mean that — based on the information reviewed — more members:

- Get appropriate treatment after a heart attack
- Get good follow-up after being in the hospital for mental illness
- Get eye exams when they have diabetes
- Get advice to quit smoking
- Get the special equipment and help they need for chronic conditions or illness

Where the Information Comes From

Information for the HMO report card comes from surveys done with plan members, visits to HMOs and data on the care HMOs and their doctors provided. The information is audited, scored and reported by **independent organizations — not by the HMOs or Delphi**. If you are interested in seeing what went into determining each of the quality measure ratings, visit the *Health Pages* on the Internet at (www.gm.thehealthpages.com).

- **Benchmark HMO** — In addition to the quality indicators developed for the report card, there is one measure — Benchmark HMO — specific to Delphi. It also appears on page 4 of *Your Personal Enrollment Information* booklet. A "Yes" means the HMO meets the highest quality, service and cost standards Delphi has for the HMOs offered. **Benchmark HMO status also means your monthly contribution will be the lowest required for any HMO offered.**

Using the Report Card

Just like any other service, the quality of health care you receive can vary a great deal. That's why it's helpful to refer to quality measures when reviewing your medical options. As you compare the costs and coverages of specific options, be sure to factor quality into your decision. While the quality indicators found in *Your Personal Enrollment Information* booklet cannot give you every detail needed to ensure you will receive quality health care, they do provide a solid starting point.

Important Notes

- In comparing HMOs, the higher HMO costs do not necessarily mean higher quality. In fact, **those HMOs with the best performance on the selected quality measures AND greatest cost-effectiveness generally have the lowest monthly contribution prices.**
- **Delphi does not endorse or recommend any particular HMO.** Some options (BMP, EMP and PPOs) have not been rated because there is not an existing structure for gathering necessary data.
- The measurements referred to are based on historical data and may not necessarily represent the quality of care you will receive in the future. Nor do the measurements represent the quality of care you will receive for any particular service from any particular HMO.

Remember

The choice of a medical plan option is a personal one. You are solely responsible for your selection. If you have any questions about a particular HMO, you should contact that HMO directly. Phone numbers are listed on the medical plan comparison chart (page 9) in *Your Personal Enrollment Information* booklet.

PERFORMANCE

PERFORMANCE

Year 2000 Medical Options

OPTIONS

- Basic Medical Plan (BMP)
- Enhanced Medical Plan (EMP)
- Preferred Provider Organizations (PPOs) (where available)
- Health Maintenance Organizations (HMOs) (where available)
- Waive medical coverage

CONTRIBUTIONS

See *Your Personal Enrollment Information* booklet for the **year 2000 monthly contributions for each medical option.** These contributions vary by the family status category you elect for 2000, as well as eligibility for Medicare. **They do not include the cost of covering any sponsored dependents for medical coverage.**

Monthly contributions for PPOs reflect the performance of each plan. Those plans with the **least favorable** financial performance have the **highest contributions.**

Monthly contributions for HMOs reflect the individual plan's performance on selected quality measures and financial performance. Those HMOs with the **best performance** on the selected quality indicators and **greatest cost-effectiveness have the lowest contributions.**

The **year 2000 contributions for sponsored dependent medical coverage** will be available in December by calling the Retiree Servicing Center at 1-800-828-9236.

A Comment About Contributions

Whether or not you elect to change your health care elections, the monthly contributions for any and all coverages may change from year to year. Currently, it is the Corporation's intent to share future increases in health care costs on the basis of 75% Corporation-paid and 25% employee/retiree-paid, on an aggregated basis. This sharing may take place through means determined by the Corporation.

You authorize and direct Delphi to deduct the required contributions for health care coverage from your monthly retirement benefits when you:

- Enroll and confirm elections over the telephone system, or
- Complete and sign the authorization form when you retire

Your authorization applies for as long as you have health care coverage — even though the required contribution amount may change. However, you may revoke your authorization to deduct contributions from your retirement benefits at any time.

To revoke your authorization, write to the Plan Administrator at the Retiree Servicing Center, P.O. Box 5113, Southfield, MI 48086-5113. If you do this, you must arrange for timely payment of monthly contributions or your action may result in your elected coverage changing to options that do not require monthly contributions.

ELECTION RULES

The **family status** you elect for medical will also apply to Extended Care Coverage, dental and vision if you elect them.

If you waive medical coverage, remember that GM and Delphi are now two separate corporations. This means that:

- **If you are a Delphi retiree** and waive your medical to be covered as a dependent under the GM plan, your medical coverage is considered non-Delphi coverage (see page 16 for effect of waiver on ECC)

If you do not call the Enrollment Center:

- Your 1999 medical option — if available — will continue in 2000 with appropriate contributions for 2000, and the dependents listed in your enrollment materials will continue to be considered eligible, or
- You will be automatically enrolled in the Enhanced Medical Plan for 2000. This would happen if:
  - Your 1999 medical plan is not offered in 2000 and you do not elect a new one, or
  - You or a covered dependent become eligible for Medicare during the first quarter of 2000 and are enrolled in a PPO or in an HMO that does not accept people who are Medicare-eligible

Defining Your Medical Options

HMOs — Health Maintenance Organizations — are health plans that help manage or coordinate your care. An HMO provides care through a network of doctors, hospitals, health care centers, laboratories, pharmacies and other health care providers. Because of their focus on keeping you healthy, HMOs offer a variety of preventive care, wellness and disease management programs. To help coordinate your care, you choose a doctor from the HMOs network. This doctor is usually a family practitioner, internist, gynecologist or pediatrician. If you enroll in an HMO, you must use network providers for all of your covered health care — except in an emergency.

PPOs — Preferred Provider Organizations — are health plans that blend aspects of an HMO and a Traditional/Indemnity plan. Your care is provided through a network of doctors and facilities — but you can go outside this network if you wish. If you use a network provider, you pay less and increase your coverage. If you use a non-network provider, you pay more and receive less coverage. Most PPOs offer a large network of providers, cover preventive care and offer some wellness and health management programs.

Traditional/Indemnity Plans are health plans that let you get care from almost any doctor or facility for covered expenses. You pay a percentage of the cost of all services you receive after satisfying your annual deductible. Traditional plans do not help you manage your health care — you decide which doctors to see and coordinate your overall care. Most traditional plans do not offer wellness or health management programs.

MEDICAL

The Health Pages

Next time you are browsing online, page over to *Health Pages* — a service for helping Delphi retirees and employees make informed health care decisions.

The site is located on the **Internet** at (www.gm.thehealthpages.com).

Using the *Health Pages* allows you to review health plan summaries and detailed quality information. You can also compare local health care choices in an easy-to-understand format.

Charts are provided to compare:

- Health plan participation
- The education, training, office hours and services of local physicians
- Provider networks and quality measures of managed care plans that serve your area
- The size, services and health plan affiliation of local hospitals

You also can find information on general health care topics including explanations and definitions, plus articles about the prevention, diagnosis and treatment of various health problems. There's advice on choosing the best provider for your particular needs along with the latest news on nutrition, caring for yourself and disease prevention.

CONSIDERATIONS

Medical coverage **options differ from each other** in:

- The amount you pay through monthly contributions
- The amount you pay in deductibles and copayments as you receive covered services and have expenses
- Limits that may be placed on your choice of providers to receive benefits
- The quality of health care services provided

HMO/PPO elections: The level of benefits you receive will depend in part on whether you use participating providers.

If you are considering an HMO and want to find out if your current physician is part of the HMO's network, call the HMO directly. Phone numbers are listed on the medical plan comparison chart (page 6) in *Your Personal Enrollment Information* booklet. **Remember, when you choose an HMO, you are choosing a plan, not a specific doctor.**

Non-Medicare retirees, surviving spouses and eligible dependents enrolled in the Basic Medical Plan (BMP), Enhanced Medical Plan (EMP) or a Preferred Provider Organization (PPO) benefit from **new features added to the Salaried Health Care Program.** (See pages 5–6 for details.)

Prescription drug coverage: The Basic Medical Plan, Enhanced Medical Plan and PPO plans all provide the same level of prescription drug coverage. Your cost depends on whether you fill your covered prescription at a network pharmacy, a non-network pharmacy or use the mail order prescription drug program. For HMO prescription drug coverage details, refer to the medical plan comparison chart in *Your Personal Enrollment Information* booklet.

If you have coverage under more than one health care plan or through Medicare, the Program will coordinate medical and ECC plan payments with those other plans.

CONSIDERATIONS

If You or a Covered Dependent Will Turn Age 65 in 2000

Typically, you become **eligible for Medicare** at age 65. When you or a covered dependent become eligible for Medicare, your monthly contributions will automatically be adjusted. At that time, you should also send a copy of the Medicare ID card to the Retiree Servicing Center (P.O. Box 5113, Southfield, MI 48086-5113).

If you are considering an HMO or PPO and you or a covered dependent will turn age 65:

- On or before April 1, 2000 — only HMOs that accept Medicare-eligible enrollees will be listed in your enrollment information.
- After April 1, 2000 — you should check the plan summary or call the HMO directly to verify whether it accepts Medicare-eligible enrollees. If you elect an HMO that does not accept Medicare-eligible enrollees, you will be notified to change options before Medicare begins.

A word of caution — PPOs do not accept Medicare-eligible enrollees.

If you or a covered dependent turns age 65 on or before February 1, 2000, the monthly contributions for health care coverage listed in *Your Personal Enrollment Information* reflect Medicare eligibility.

If you or a covered dependent turns age 65 after February 1, 2000, the monthly contributions listed in *Your Personal Enrollment Information* booklet do not reflect Medicare eligibility. Your health care coverage contribution (if any) will be lower — if your current plan accepts Medicare — to reflect Medicare eligibility when it occurs.

Special Option When Medicare-Eligible

In many areas, Delphi now offers options specifically designed for Medicare-eligible individuals. This option is commonly called a Medicare HMO. It may offer a better combination of care, cost and benefits than original Medicare and other Delphi medical options.

When you or a covered dependent become Medicare-eligible, you will receive more information about these new options.

A chart comparing your medical options is included on pages 6–7 of *Your Personal Enrollment Information* booklet. Refer to the GM booklet titled *Your Benefits in Retirement* (July 1996) — with descriptions that apply to your Delphi benefits — for more detailed information about your medical options.

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Extended Care Coverage (ECC)

OPTIONS

- Continue ECC
- Waive ECC

If you waived ECC during a previous enrollment, you may re-elect ECC only if you had waived coverage to be covered as a dependent of another Delphi salaried employee or retiree who has ECC. (See details under "Election Rules" on this page.)

Changing your medical option does not affect your ECC coverage.

CONTRIBUTIONS

See page 8 of *Your Personal Enrollment Information* booklet for the **year 2000 monthly contributions for ECC.** They are based on your family status election for 2000.

Refer to the GM booklet titled *Your Benefits in Retirement* (July 1996) — with descriptions that apply to your Delphi benefits — for more details about ECC.

ELECTION RULES

You must elect one of the medical options to have ECC, which is provided at the same family status category as your medical coverage.

If you waive medical coverage, you will not be able to elect ECC again in the future unless:

- **You are a Delphi retiree** and waive medical to be covered as a dependent of a Delphi salaried employee, or you are a dependent of a Delphi salaried retiree who has ECC. In such cases, you may add ECC coverage at a future date when you again elect Delphi medical coverage.

Important: If you are a Delphi retiree and waive medical to be covered by the GM plan, you will not be able to elect ECC through Delphi in the future. To continue ECC coverage in this case, you must continue to be covered by the GM plan.

If you terminate or drop your ECC coverage, you cannot reinstate it at a later date other than as described above.

Sponsored dependents are **not** eligible for ECC.

CONSIDERATIONS

Extended Care Coverage **supplements your medical coverage** when certain services are required. It covers:

- Hospital, skilled care or home health care services that exceed medical plan limits
- Custodial care, which is not covered by the medical plan

ECC has **no deductible or copayment.** The plan pays benefits up to an annual maximum of $50,000 per covered person

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ECC pays:

- An approved skilled rate for hospital or skilled nursing facility stays beyond the medical plans' limits; skilled care at a nursing facility; and home health care — skilled only or a mixture with unskilled — that exceeds medical plan coverage
- Up to $35 a day for unskilled care at a hospital, skilled nursing facility or licensed nursing home, or received through a home health care agency or by a privately contracted qualified nurse professional approved by the ECC carrier

Long-Term Care (LTC) Insurance: A Reminder

If you currently have LTC Insurance through John Hancock, you do not need to re-enroll to continue coverage.

To purchase LTC Insurance, you or your spouse can apply for coverage at **any time** through John Hancock. You **cannot** purchase this coverage through the Health Care Enrollment System.

Questions and How to Enroll

For more information or to enroll, call John Hancock — Monday through Friday between 8:30 am and 4:30 pm Eastern time.

- 1-800-200-6773
- 1-800-255-1808 (TTY)

DENTAL

DENTAL

Year 2000 Dental Options

OPTIONS

- Traditional Dental Plan
- Alternative Dental Plans (where available)
- Waive dental coverage

CONTRIBUTIONS

See *Your Personal Enrollment Information* booklet for the **year 2000 monthly contributions for each option.** Contributions vary by your family status election for 2000.

ELECTION RULES

Sponsored dependents are **not** eligible for dental coverage.

CONSIDERATIONS

Similar to HMOs, **Alternative Dental Plans** require the use of network providers for you to receive benefits. Call the plan directly for a list of participating dentists. If you elect the **Traditional Plan,** you can choose to see any dentist and receive benefits.

Both types of dental plans cover similar services based on reasonable and customary charge standards.

The chart on page 19 **compares the dental options at-a-glance.**

The Traditional Dental Plan and Alternative Dental Plans (if any) available in your area are **summarized on page 9** of *Your Personal Enrollment Information* booklet.

This Program coordinates payment with benefits from other dental plans.

Changing your medical option does not affect your dental coverage.

Dental Options At-A-Glance

Features	Traditional Dental Plan		Alternative Dental Plans* (if available)
Monthly Contributions for 2000	Yes		Yes
Deductible	$0		$0
Copayments	**Plan pays****	**You pay**	
Preventive	100%	0%	See the dental plan comparison chart found on page 9 in *Your Personal Enrollment Information* booklet
Minor Restorative	90%	10%	
Major Restorative	50%	50%	
Orthodontics***	50% (up to $1,500 per person)	50%	
Annual Maximum	**$1,400 per covered person**		

** Alternative dental plans require the use of network providers for you to receive benefits.*
*** Plan copayments are at reasonable and customary levels.*
**** For covered dependents under age 19.*

Refer to the GM booklet titled *Your Benefits in Retirement* (July 1996) — with descriptions that apply to your Delphi benefits — for more detailed information on both types of dental plans.

DENTAL

DPH-OTM-0000118

Year 2000 Vision Options

OPTIONS

- Vision Plan
- Waive vision coverage

CONTRIBUTIONS

There are **no contributions required** for vision coverage for 2000.

ELECTION RULES

Sponsored dependents are **not** eligible for vision coverage.

CONSIDERATIONS

The chart on the next page shows your **vision coverage at-a-glance under the vision network.** More detailed information is found in the GM booklet titled *Your Benefits in Retirement* (July 1996) — with descriptions that apply to your Delphi benefits.

This Program coordinates payment with benefits from other plans.

You may be responsible for any **costs above the reasonable and customary charge (R&C).** R&C is based on the actual amount a provider charges for services or materials up to a reasonable limit set by the carrier.

Changing your medical option does not affect your vision coverage.

Vision Benefits At-A-Glance

Benefit	Frequency	Network Provider	Out of Network	Out of Area*
Vision Exam	Once each calendar year	Covered in full	Enrollee reimbursed based on regional fee schedule	Enrollee reimbursed based on R&C** minus $7 copay
Frames	Once every two consecutive calendar years	Covered frames available at no cost. 30% discount on non-covered frames	Enrollee reimbursement is $21	Enrollee reimbursement is $15 minus a $10 copay, if applicable***
Lenses	Once every calendar year	Covered lenses available at no cost	Enrollee reimbursement based on regional fee schedule	Enrollee reimbursement based on R&C** minus $10 copay
Contact Lenses	Once every calendar year in place of regular lenses	Enrollee pays difference between providers charge and $75	Enrollee reimbursement is $65	Enrollee reimbursement is $75 minus $10 copay

*Note: A vision exam provided by a non-network opthamologist results in the enrollee being reimbursed based on R&C** minus $7 copay*

** Out of Area occurs when there is no network provider within 25 miles of the enrollee's residence.*
*** R&C stands for reasonable and customary charge.*
**** There is a combined annual copayment of $10 for lenses and frames.*

VISION

How to Verify Dependent Information

You should review the accuracy of your dependent information/data as listed on page 2 in *Your Personal Enrollment Information* booklet. This list shows dependents — including sponsored dependents — **who were covered as of August 1, 1999** under your Delphi health care coverage.

When you review the list, check that each dependent shown is eligible and that the information provided is correct.

- Do nothing if all of the dependents continue to meet eligibility requirements, the information on the form is correct and you want to keep the same health care coverage.
- Dependent information/data changes:
  - **To cancel any dependents who are no longer eligible or to correct a dependent's Social Security number,** call the Enrollment Center at 1-800-462-5184. During the same call, you can review your current health care coverage or make changes to your choices.
  - **To correct other dependent information** — such as relationship status, date of birth or spelling of a dependent's name — or to add a dependent call the Retiree Servicing Center at 1-800-828-9236.

How to Determine if a Dependent Is Eligible

The charts on pages 24–26 walk through the eligibility requirements for dependents. You should review them as you verify the eligibility for each dependent. If you have any questions about whether a dependent meets the eligibility criteria, call the Enrollment Center at 1-800-462-5184 and speak with a Customer Service Representative.

Remember, if you have an ineligible dependent covered and claims and/or expenses are paid, you will need to make reimbursement for all payments made for that person from the date he or she stopped being eligible for the Corporation's health care coverage.

Is Your Spouse Eligible?

If you married your current spouse:

1. Before you retired from Delphi, your spouse is eligible as a dependent with Corporation contributions.
2. After you retired from Delphi and before July 1, 1988, your spouse is eligible as a dependent with Corporation contributions.
3. After you retired from Delphi and on or after July 1, 1988, you may purchase medical coverage for your spouse as a **sponsored dependent.**

If you are the surviving spouse of a Delphi salaried employee or retiree, you cannot add a new spouse to your Delphi coverage.

Sponsored Dependents

Sponsored dependents are not included in your family status election or the medical contribution amounts listed in *Your Personal Enrollment Information* booklet. You should, however, verify the eligibility of your sponsored dependents. See the chart on page 26.

Information about medical coverage contributions for sponsored dependents will be available in December by calling the Retiree Servicing Center. Sponsored dependents are not eligible for Extended Care Coverage, dental or vision.

The rules and steps for adding a dependent have not changed from last year. To add a dependent, you must call the Retiree Servicing Center at 1-800-828-9236.

If you do not call the Enrollment Center, you will have represented that your current dependents remain eligible for coverage and that their information is accurate.

Just because a **person qualifies as an exemption for personal income tax** purposes does **not** necessarily mean he or she is eligible for medical, ECC, dental and vision coverage.

If you retired on or after July 1, 1988, you can only cover your spouse or children if they were eligible for coverage at the time of your retirement. New dependents can receive medical coverage as **sponsored dependents** if they are eligible and you pay the full cost of that coverage.

DEFINITIONS

These definitions are included to help you understand terms that appear on the dependent eligibility charts on pages 24-26.

QMCSO or Qualified Medical Child Support Order is a court order that meets the provisions of Federal law requiring you to provide health care coverage for the child identified, if the child meets all tests except for residency and dependency. The child must be the child of the Delphi retiree.

Children enrolled as of October 31, 1992 under the former **"principally supported child or legal guardianship"** provisions are eligible if:

- They remained continuously eligible and enrolled, and
- They are legally claimed as an exemption on your personal Federal income taxes

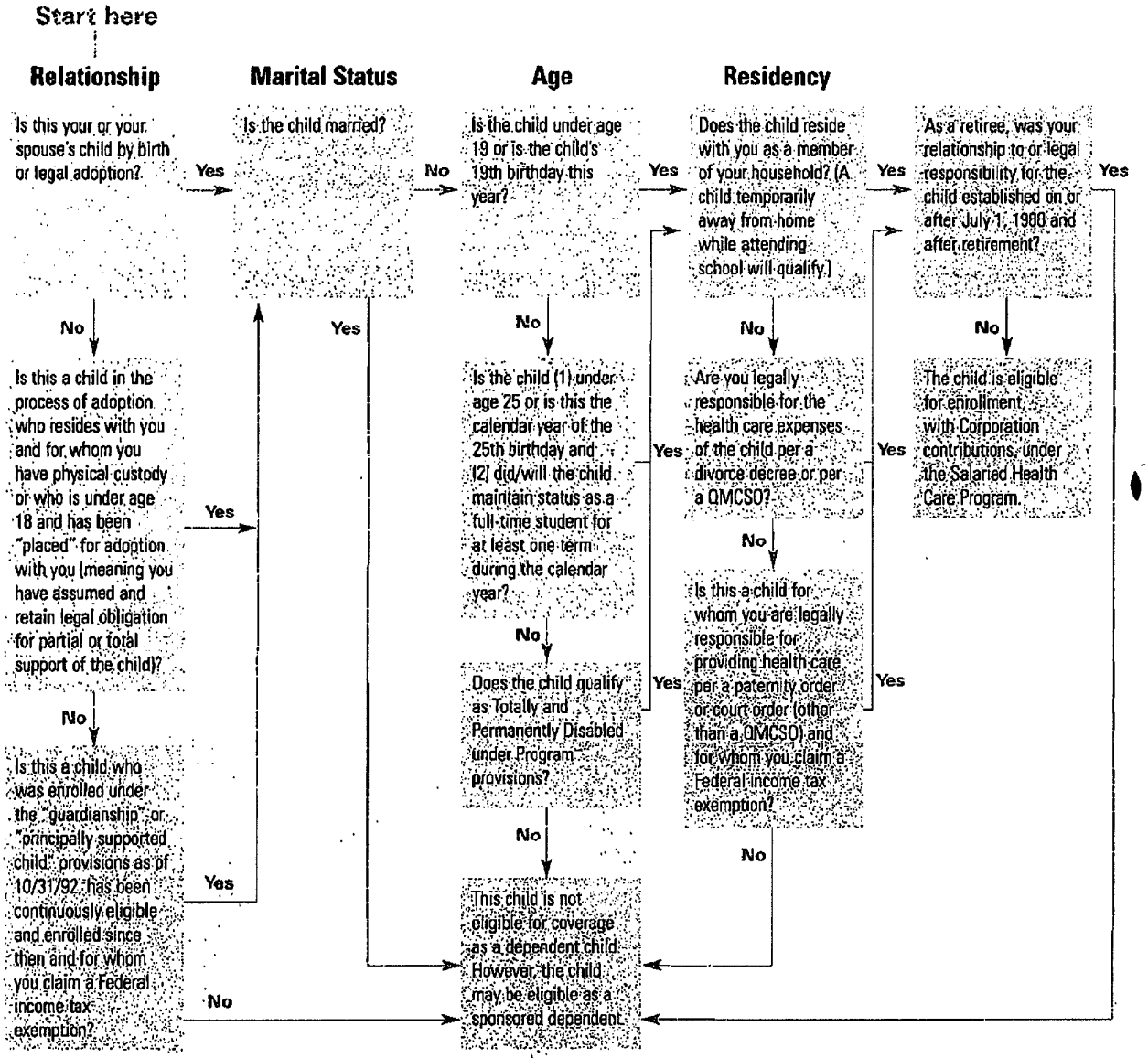
The Program's definition of **"Totally and Permanently Disabled"** is having a medically determinable physical or mental condition that prevents the child from engaging in substantial gainful activity and which can be expected to result in death or be of a long-term or indefinite duration.

The following charts are excerpts from the *Guide to Dependent Eligibility* for the Salaried Health Care Program. To request a copy of this guide, call the Enrollment Center at 1-800-462-5184.

DEPENDENTS

If You Are a Salaried Retiree and Have Dependent Children

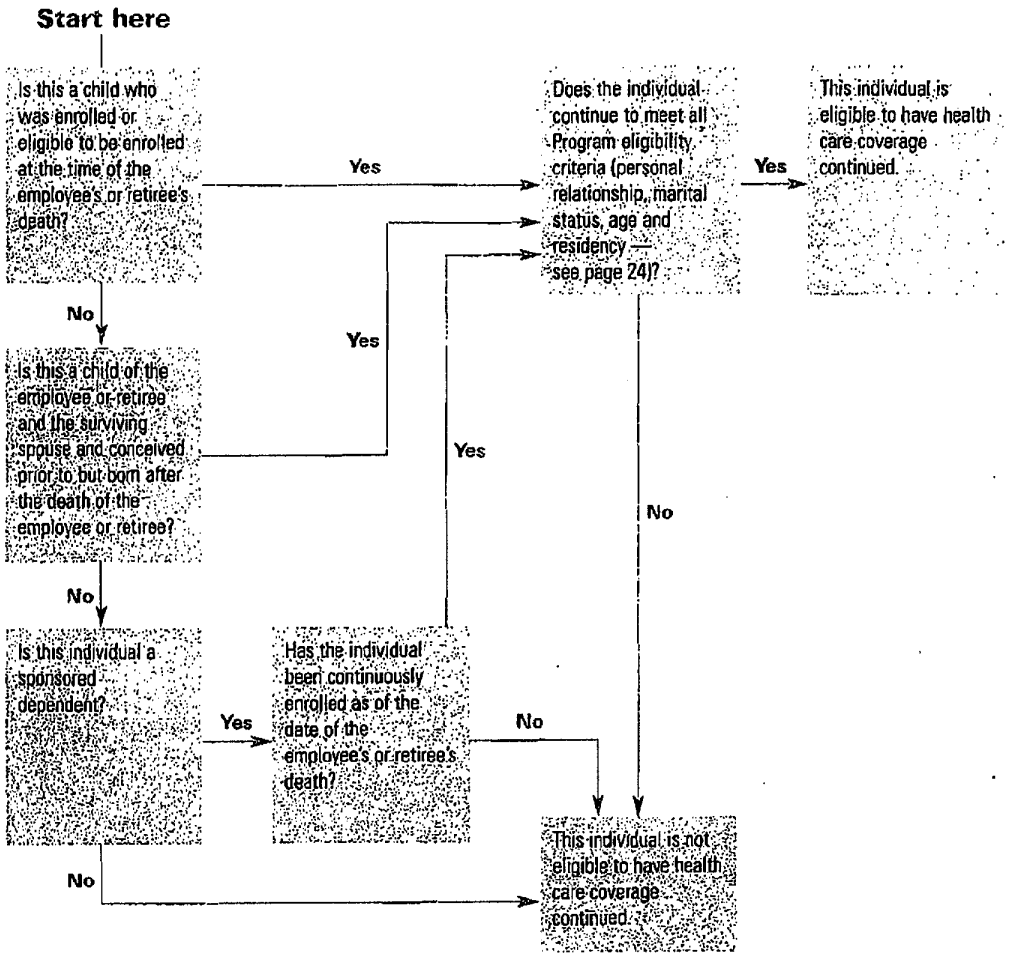
Your children must satisfy each of four tests to be eligible for health care coverage as a dependent. These tests — relationship, marital status, age and residency — are summarized in the following chart. Start with the top box under "Relationship" and walk through the chart to determine the eligibility of each child.



See page 23 for definitions of "Totally and Permanently Disabled" and "Qualified Medical Child Support Order (QMCSO)" and the chart on page 26 for sponsored dependent eligibility.

If You Are a Surviving Spouse of a Salaried Employee or Retiree

Check the following chart to determine if your children will remain eligible for health care coverage during 2000.



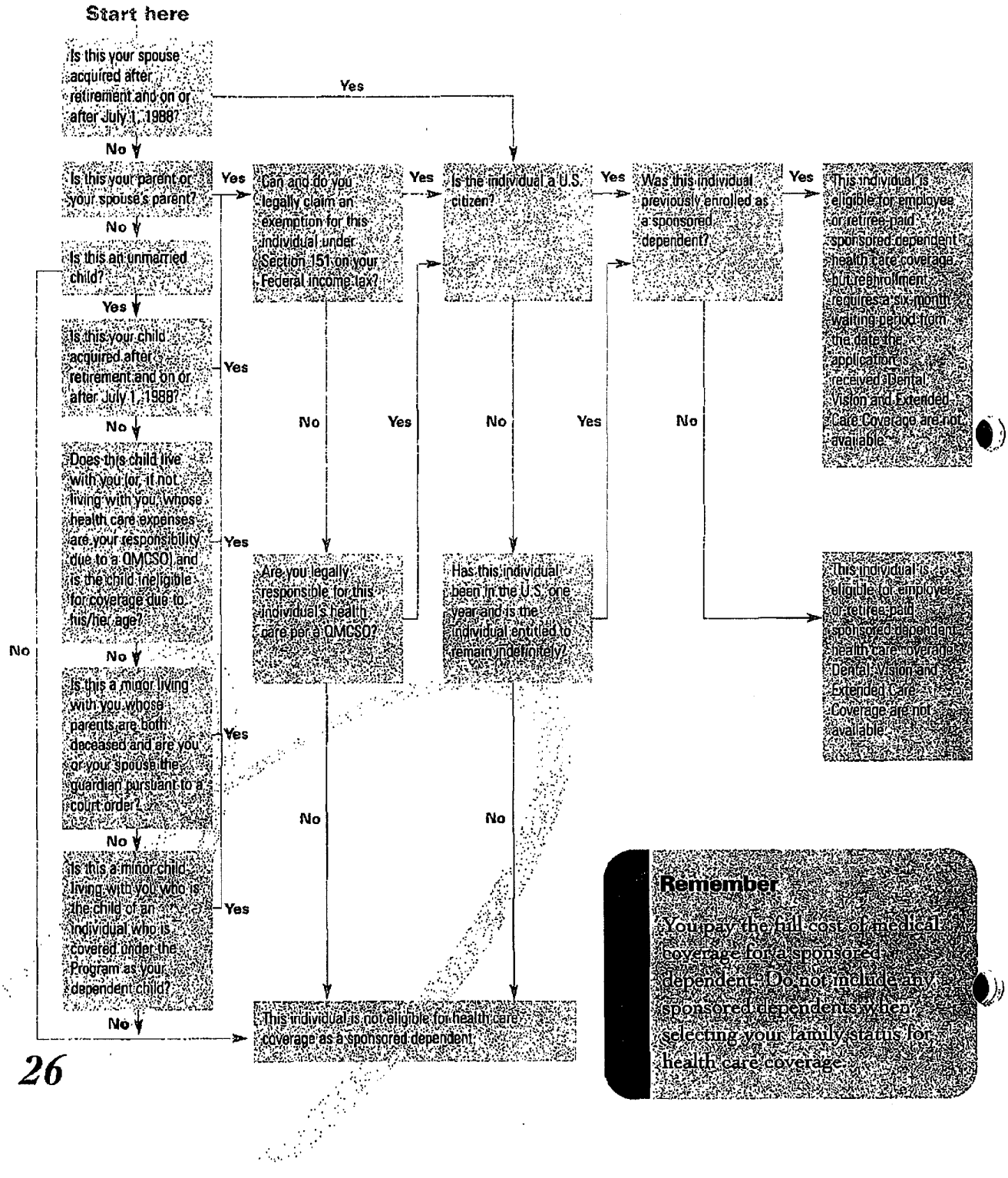
Surviving spouses can only elect coverage for "you only" or "you and children."

A surviving spouse may not:

- Enroll a new spouse
- Enroll new children or stepchildren
- Enroll or re-enroll a sponsored dependent

To Determine if a Dependent Qualifies as a Sponsored Dependent

The following chart walks through the requirements for a sponsored dependent of a salaried retiree or employee. Review it to verify that your current sponsored dependents remain eligible. Also, dependents who are not eligible for coverage as your dependents may qualify as sponsored dependents.



Remember

You pay the full cost of medical coverage for a sponsored dependent. Do not include any sponsored dependents when selecting your family status for health care coverage.

About This Booklet

Delphi Automotive Systems reserves the right to amend, modify, suspend or terminate any of its benefits plans or programs by the action of its Board of Directors, or individual or other committee expressly authorized by the Board to take such action. The benefits to which a retiree or surviving spouse is entitled are determined solely by the provisions of the applicable benefit program. Absent an express delegation of authority from the Board of Directors, no one has the authority to commit the Corporation to any benefit or benefit provisions not provided for under the applicable benefit program, or to change the eligibility criteria or any other provisions of such program.

Delphi Automotive Systems also reserves the right to construe and interpret these benefit programs. Each benefit program also has an appeal procedure which serves as the exclusive manner for resolution of all disputes concerning the interpretation or application of the program. The decision on appeal is final and binding.

DELPHI
Automotive Systems

September 1999

DELPHI
Automotive Systems

health care 2000

Your Personal Enrollment Information

For Delphi Salaried Retirees and Surviving Spouses

To enroll for Health Care 2000: Call 1-800-462-5184 October 4–15, 1999

coverage you may have made between August 1, 1999, and October 15, 1999, but other changes will not be reflected.

Follow the instructions on your confirmation statement if any of the information is incorrect.

Consider This...

If you decide to change your health care or the dependents you cover for 2000, unfold the back cover. You will find your Decision Worksheet, a guide to follow when you call to make your changes.

In the *Health Care Decision Guide*, also enclosed in this packet, you can find more specifics — about election rules and items to consider. You may want to check this guide to help answer your questions.

The benefits provided under the Delphi Benefit Plans and Programs are the same as those offered under the GM Benefit Plans and Programs. Therefore, the benefit descriptions in the GM booklet titled *Your Benefits in Retirement* (July 1996) apply to your Delphi benefits and can be used as a reference.

IMPORTANT NOTICE
For Retirees of Delphi Automotive Systems Retiring On or After February 1, 1999

Delphi Automotive Systems became a wholly independent, free-standing company effective May 28, 1999. It is now completely separate from General Motors. As a result, Delphi retirees are now participants in retiree benefit plans and programs which are comparable to those of General Motors. The options listed in *Your Personal Enrollment Information* are sponsored by Delphi and refer to your benefits as a Delphi retiree.

MO, PPO and Alternative Dental Plans
one numbers listed on pages 6 and 9 in this booklet

hn Hancock (Long-Term Care)
800-200-6773 (1-800-255-1808 TTY)

DE

New for 2000 Enrollment

For 2000, we are introducing a new medical plan comparison chart — on pages 6 and 7 — designed to help you quickly review your medical options without having to read through pages of details on each plan. It provides a side-by-side overview of each of the medical plans available to you — all on one chart.

As you review the new comparison chart, it's important to note that **the plan details and benefits for each option remain unchanged from last year. However, copayments for some HMOs have increased slightly.** This means that most Delphi-offered HMOs now have the same copayments. Copayment information is shown on the new comparison chart.

The detailed health plan summaries that were provided in previous years are still available from these sources:

- **Information Request Line** — to have the health plan summaries either sent to you by fax or through the mail
  - Call 1-800-462-5185, September 27 through October 15 (24 hours a day, 7 days a week)

  (If you do not have access to a fax machine, be sure to call early enough to allow time for mailing.)
- ***Health Pages*** — to access the health plan summaries **and** detailed quality information on the Internet
  - Visit www.gm.thehealthpages.com

See the *Health Care Decision Guide* for more updates on the 2000 enrollment.

Your Decision Worksheet

This worksheet is designed to help you record your year 2000 enrollment elections. Refer to the health care options in this booklet as you make your decisions.

The information you write in the shaded areas will be the information asked of you by the telephone voice response system.

When you have entered all your contributions, add them up. The sum will be your total monthly contributions for your year 2000 health care coverage.

Code or dependent code — refers to the number immediately to the left of the name of any option or dependent.

Monthly contribution — is the amount listed next to an option; be careful to transfer the right contribution for your family status category to your Decision Worksheet.

If you need to correct a dependent's Social Security number, be sure to write it down in the space provided.

If you waive coverage, the voice response system will prompt you for the reason. Here is a list of the codes for your reasons:

- ☐ 1 = You are a dependent covered under the GM Health Care Program
- ☐ 2 = You are a dependent covered under the Delphi Health Care Program
- ☐ 3 = You have non-GM or non-Delphi coverage (including Saturn or Hughes plan)

Then, listen to the system prompts and follow the instructions.

Call 1-800-462-5184 to enroll — October 4 through October 15, 1999

Voice Response: Every day, 4 am – Midnight (Eastern time) / Representatives: Monday – Friday, 8 am – 5 pm (Eastern time)

Step 1: To Enter The Telephone Enrollment System

Personal Information

Social Security Number ___ - ___ - ____

Personal Identification Number (PIN) (from page 2 of this booklet) ____

Step 2: To Confirm Your Dependents

Dependent Information

Are all of your listed dependents eligible? (1 = yes; 2 = no) ☐

Do the following for each dependent you cancel:
Code of dependent to cancel ☐

Are the Social Security numbers correct? (1 = yes; 2 = no) ☐

Do the following for each number you change:
a. Dependent code
b. Correct Social Security number

a. ☐ b. ___ - ___ - ____

Are there other dependent changes? (* = yes; 1 = no) ☐

Step 3: For Your 2000 Salaried Health Care Coverage

Select coverage for 2000:
1 = Keep 1999 coverage at year 2000 contributions
2 = Review current coverages
3 = Change some or all coverages
4 = Waive all coverages

☐ If you waive all coverages, follow phone instructions

Family Coverage Status
Your family status applies for all health care coverages you elect.

	Election	Monthly Contributions
Medical Plan	____ If you waive medical, follow the phone instructions	$ ___ . __
Extended Care Coverage (ECC)	☐	$ __ . __
Dental Plan	__	$ ☐ . __
Vision Plan	☐	$ 0 . 0 0

Total Monthly Contributions $ ___ . __

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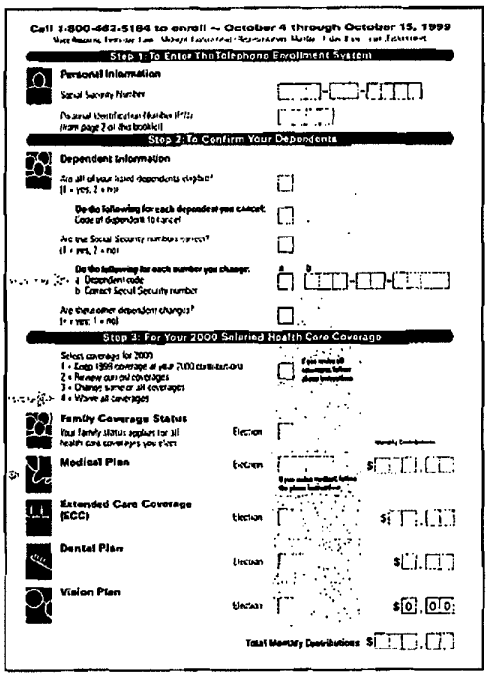
Fold Out This Flap For Your Decision Worksheet


Call 1-800-462-5184 to enroll — October 4 through October 15, 1999

Step 1: To Enter The Telephone Enrollment System

Personal Information

Social Security Number

Personal Identification Number (PIN) (from page 2 of this booklet)

Step 2: To Confirm Your Dependents

Dependent Information

Are all of your listed dependents eligible? (1 = yes, 2 = no)

Do the following for each dependent you cancel: Code of dependent to cancel

Are the Social Security numbers correct? (1 = yes, 2 = no)

Do the following for each number you change: a Dependent code b Correct Social Security number

Are there other dependent changes? (1 = yes, 2 = no)

Step 3: For Your 2000 Salaried Health Care Coverage

Select coverage for 2000: 1 = Keep 1999 coverage at your 2000 contribution level; 2 = Renew current coverages; 3 = Change some or all coverages; 4 = Waive all coverages

Family Coverage Status — Your family status applies for all health care coverages you elect — Election

Medical Plan — Election — $

Extended Care Coverage (ECC) — Election — $

Dental Plan — Election — $

Vision Plan — Election — $0.00

Total Monthly Contributions $

Retiree Enrollment Center
1-800-462-5184
October 4–15, 1999

Voice response:
Available every day
4 am to midnight, Eastern time

Representatives:
Available Monday through Friday
8 am to 5 pm, Eastern time

After Enrollment

1. You will receive a statement confirming your health care elections for 2000 early in November.

2. Your year 2000 coverage elections take effect January 1, 2000. Required contributions will be deducted from your retirement benefits, as authorized, beginning with the January check.

Please Note

If you changed your health care coverage, dependents and/or address after August 1, 1999, your changes may not be reflected in your personalized information.

Your confirmation statement will show any changes in your health care coverage you may have made between August 1, 1999, and October 15, 1999, but other changes will not be reflected.

Follow the instructions on your confirmation statement if any of the information is incorrect.

Where to Find More Information . . .

Use this Resource...	For...
Retiree Enrollment Center 1-800-462-5184 (1-800-872-8682 TTY) October 4–15 ■ Voice Response: Every day, 4 am to Midnight ■ Representatives: Monday through Friday, 8 am to 5 pm (Eastern time)	■ Reviewing your current health care coverage ■ Changing your health care coverage ■ Canceling dependents no longer eligible
Retiree Servicing Center 1-800-828-9236 (1-800-872-8682 TTY) Monday through Friday, 9 am to 4 pm (Eastern time)	■ Adding a dependent or correcting a date of birth, relationship status or the spelling of a name ■ Year 2000 monthly medical contributions for sponsored dependents (available December 1999) ■ Requesting a copy of *Your Benefits in Retirement*
Health International 1-877-299-4635 24 hours a day, 7 days a week (For non-Medicare retirees, surviving spouses and eligible dependents in BMP, EMP or a PPO)	■ A "best practices" review for medical appropriateness of any surgery, hospital stay, skilled nursing facility admission or home health care service — a phone call is required in each case ■ Information about voluntary Disease Management and Centers of Excellence
Health Pages www.gm.thehealthpages.com	■ Health plan quality performance information and detailed health plan summaries ■ Comparisons of local health care choices ■ Physician information
Information Request Line 1-800-462-5185 September 27 – October 15 24 hours a day, 7 days a week	■ Requesting detailed health plan summaries to be either sent to you by fax or through the mail
Plan Carriers ■ Medical: Phone numbers listed on page 6 in this booklet ■ Retail Pharmacy and Mail Order Prescription Drug Program: 1-800-464-4679 ■ Mental Health and Substance Abuse (Careline): 1-800-235-2302 ■ Extended Care Coverage (ECC) (Connecticut General): 1-800-523-4626 ■ Dental (Jardine Group Services): 1-800-729-1227 ■ Vision (MetLife): 1-800-638-0166	■ Information about claim payments and coverage
HMO, PPO and Alternative Dental Plans Phone numbers listed on pages 6 and 9 in this booklet	■ Participating doctors, hospitals, dentists and other providers
John Hancock (Long-Term Care) 1-800-200-6773 (1-800-255-1808 TTY)	■ Information about Long-Term Care Insurance or to enroll

DELPHI
Automotive Systems

September 1999

Choices for Your Delphi Coverage

The Salaried Health Care Program provides Medicare-eligible retirees two primary alternatives for medical coverage:

Basic Medical Plan or Enhanced Medical Plan

(coordinates with traditional Medicare Part A and Part B)

Traditional Medicare

Traditional Medicare is the way Medicare has historically provided benefits. It's often called fee-for-service coverage or indemnity coverage. There are two parts:

- **Part A (Hospital Insurance)** — helps pay for care in hospitals and skilled nursing facilities, and for home health and hospice care. Part A coverage is generally automatic if you are age 65 or older, or are disabled.
- **Part B (Medical Insurance)** — helps pay for doctors, outpatient hospital care and certain other services not covered under Part A. Part B is voluntary and you must enroll to be covered. If you choose Part B, you also pay a Medicare premium.

Under traditional Medicare, when you receive health care services, **you pay a deductible plus coinsurance or copayments depending on the type of care you receive.**

Delphi-offered Medicare HMOs

(if available in your area)

A Newer Look at HMOs

Medicare-eligible individuals have alternatives to traditional Medicare that provide options that are similar to those available to the non-Medicare population. Of these new options, the most widely available are Medicare HMOs.

Medicare HMOs may offer a better combination of care, cost and benefits than traditional Medicare and your current medical coverage. **Medicare HMOs provide coverage for:**

- All of the same services covered by traditional Medicare Part A and Part B

PLUS

- Many health care services traditional Medicare does not cover, such as annual physicals and preventive services

With Medicare HMOs, most services are covered at 100% with no deductible, provided you use network physicians. You pay only a small, fixed copayment for some services, such as office visits.

Note: Refer to *Your Personal Enrollment Information* booklet for Medicare HMOs (if any) available in your area.

Considering a Delphi-offered Medicare HMO

Quality Health Care at Affordable Prices

Providing choices that help you receive quality health care at affordable prices is an important goal. We are continuing our efforts to reach this goal by offering Medicare HMO options for salaried retirees and surviving spouses. **With Delphi-offered Medicare HMOs, your out-of-pocket costs are generally lower than those you would have under traditional Medicare.**

When you use the doctors, hospitals and other professionals who participate in the Medicare HMO network, the Medicare HMO:

- Pays 100% for Medicare-covered services and provides many other health care services traditional Medicare does not cover
- Requires only a small fixed copayment for some services such as office visits
- Emphasizes preventive care for early detection and offers healthy lifestyle programs to help keep you healthy
- Eliminates the need to file most claims

Delphi-offered Medicare HMO Eligibility

If either you or an eligible dependent are eligible for Medicare, you may want to consider a Delphi-offered Medicare HMO option. **Only the HMOs in your area** that will accept Medicare-eligible enrollees are listed in *Your Personal Enrollment Information* booklet.

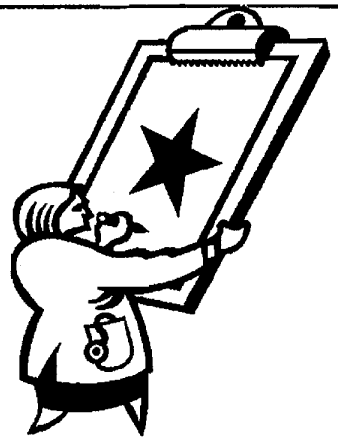
To participate in a Medicare HMO, you must continue to be covered under Medicare Parts A and B. **When you elect a Delphi-offered Medicare HMO:**

- Everyone who is eligible for Medicare — you, your spouse or another covered dependent — will be covered by the Medicare HMO
- Others who are not yet Medicare-eligible will receive coverage under that HMO's regular Delphi-approved plan

Medicare HMOs and Quality

1 **Medicare HMOs must meet the high standards Delphi sets for the HMOs offered to salaried retirees.** Performance information on specific HMOs is included on page 4 of *Your Personal Enrollment Information* booklet.

2 **The Federal government screens and approves Medicare HMOs.** This extensive review process is conducted by the Health Care Financing Administration (HCFA), the same Federal government agency responsible for traditional Medicare. The review generally lasts from six months to one year before an HMO is qualified under Medicare.



3 **Nearly 90% of retirees enrolled in Medicare HMOs said they faced no barriers in gaining access to medical care.** This finding was part of a government-funded study conducted by the Physician Payment Review Commission, a group that advises Congress on medical issues.

4 **Many independent studies have been conducted on retiree satisfaction with Medicare HMOs.** HCFA is accelerating efforts to monitor Medicare HMOs so that retirees receive high levels of care and service that are needed by the elderly population.

An independent study uncovered these facts:

Most Medicare HMO members seem pleased with their coverage and the care they receive from the doctors and other health care professionals. According to a national study of the general Medicare population enrolled in Medicare HMOs, retiree satisfaction is just over 93%, mainly due to low costs and enhanced prescription drug benefits.

Once retirees enroll in a Medicare HMO, they generally remain enrolled. At GM for example, 99% of enrollees are happy with their HMO. Just 1% of GM retirees who enrolled in a Medicare HMO have changed their mind. Why? The most common reasons are because they moved outside the HMO service area, or their doctor moved or dropped out of the network.

Making Your Decision

How do you decide which option is right for you? You may want to start by comparing your Delphi medical options. The chart below is designed to help you.

If this is your situation...	Consider... Basic or Enhanced	Medicare HMO
I expect significant medical care next year and want to minimize my expenses.		✔
A family member with a chronic condition requires frequent doctor visits.		✔
I travel a lot and want to be able to see a doctor for routine, non-emergency care.	✔	
I generally do not use health care much during the year.	✔	✔
I have a child who is in college out of the area.	✔	Check with HMO to verify coverage
I am interested in having a coordinated plan of care for the medical treatment I need.		✔
It's important to me to have routine preventive care services, like annual physicals, flu shots, mammograms and cholesterol screenings.		✔

Coverage for "Snowbirds"

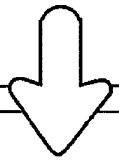
Some HMOs have special arrangements for people who travel for extended periods of time. Through "reciprocal agreements" with HMOs in other areas of the country, an HMO in one area may negotiate with an affiliated HMO in another area — such as Florida — to cover each other's participants. Even if your HMO does not have a reciprocal agreement, you may still be able to secure coverage if you make advance arrangements with your Primary Care Physician and HMO. And, of course, you have access to emergency and urgent care services. Emergency care treats severe symptoms such as chest pains and broken bones. Urgent care treats less serious conditions such as cuts, bruises and suture removal.

Medicare and You

Caution! Medicare HMOs Marketed to Individuals

The Health Care Financing Administration (HCFA) is the Federal agency that runs Medicare. It's also a resource for Medicare information (see "More About Medicare"). However, many other messages may be directed at you from different HMOs — via the mail, through phone solicitations and in TV, radio and print ads. This information may describe Medicare HMO health plan coverage you can purchase as an individual. **Exercise caution!**

It might seem like the benefits are the same — and the HMO may even have the same name as a Medicare HMO being offered by Delphi. However, **Medicare HMO plans offered outside the Salaried Health Care Program will not offer the same coverage as the Delphi-offered Medicare HMOs.** This is particularly true in the area of prescription drugs, where Delphi-offered Medicare HMOs usually provide more generous prescription drug benefits.



Important!

If you decide to elect a Delphi-offered Medicare HMO, it is very important that you elect it through the enrollment process. **You may put your Delphi-sponsored coverage at risk if — at any time — you join a plan not offered by Delphi.**

Before deciding to enroll in a plan not offered under the Salaried Health Care Program, call the Retiree Enrollment Center at 1-800-462-5184 (1-800-872-8682 TTY) to learn how such a decision would affect your Delphi coverage.

Keep In Mind!

As you see, hear and read more about the newer Medicare options, keep in mind:

- Traditional Medicare is still available under Medicare Part A and Part B by electing the Basic Medical Plan or Enhanced Medical Plan.
- If you enroll in a Delphi-offered Medicare HMO, you are not giving up Medicare; you're simply receiving your Medicare benefits — plus some additional benefits — through an HMO.
- Be cautious of commercial HMOs that may seek your enrollment in one of their Medicare HMO options. If you have questions, call the Retiree Enrollment Center first.

Food for Thought

Did You Know?

Delphi currently pays a significant portion of your health care costs while you are receiving benefits through Medicare. For example, after any applicable deductible is satisfied, Delphi currently pays:

- Covered prescription costs after your Delphi copayment
- Covered vision and dental costs after your Delphi copayment
- Your Medicare Part B premium, which in 1999 is $546 for the full year (you are reimbursed for this amount over 12 months in your monthly retirement check)
- The difference, subject to cost sharing, between what Medicare pays and what your Delphi medical option covers; for example — the Medicare Part A deductible for hospitalization ($762 in 1999)

Important!

If you elect a Delphi-offered Medicare HMO for the first time, be sure to complete and return the HCFA application form that will be packaged with your confirmation statement (mailed in early November). **If you fail to return this form, you will be placed in the Enhanced Medical Plan.**

Note: Some current Delphi-offered HMOs will "transition" and become Medicare HMOs in 2000. If you are enrolled in this type of HMO, you will need to fill out and return the HCFA application as well.

More About Medicare from Washington, D.C.

- Look for the ***Medicare & You*** **handbook** in the mail. This year, HCFA is mailing the handbook to all 39 million Medicare beneficiaries in September and October.
- Call toll-free **1-800-MEDICARE** to speak with an operator or listen to pre-recorded answers to frequently asked questions. TTY service is available for the hearing impaired at 1-877-486-2048.
- Visit the **Medicare web site** (www.medicare.gov) for online HMO information for your area, answers to questions and ideas to help you choose a Medicare HMO.

You Can Change Your Mind!

If you enroll in a Delphi-offered Medicare HMO, you can change your mind later and switch to the Basic or Enhanced Medical Plan at any time in 2000.